Department of Health Services
Food and Drug Branch
601 North 7th Street, MS357
P.O. Box 942732
Sacramento, CA 94234-7320
Phone (916) 445-5224
Fax (916) 322-6326

APPLICATION FOR EXEMPTEE LICENSE FOR HOME MEDICAL DEVICE RETAILER

Read instructions on attached sheet, if not applicable write N/A; unsigned or incomplete applications will not be processed.

☐ **Renewal** ☐ **New Exemptee** ☐ **Transfer** ☐ **Additional License**

(Please print or type)

1. Name of Applicant:	Last	First	Middle	Former
Residence address:	Number and Street	City	State	Zip Code
Home phone number: ( )	Date of birth:	Social Security number:	2. Previous Exemptee license Number	
3. Name of employer:				
Address of employer:	Number and Street	City	State	Zip Code
Work phone number: ( )	HMDR license number of employer:	Expiration date:		

Has the applicant ever been convicted of a felony? ☐Yes ☐No If "yes," provide an explanation on a separate sheet.

4. Please provide the following information to determine if you meet the minimum qualifications (The following questions are for new applicants only).

Do you have a high school diploma or equivalent? ***(Attach a copy to the application)*** ☐Yes ☐No

Do you hold any of the following professional certifications or licenses ***(Check all that apply & forward documentation)***

Respiratory Therapist ☐ LVN ☐ RN ☐ PT ☐ OT ☐ Pharmacy Technician ☐ Other_____

Have you had one year or more paid experience related to the distribution or dispensing of dangerous drugs or dangerous devices? ***(Provide proof of 1 year experience)*** ☐Yes ☐No

Have you completed training program(s) that address the following:

State and Federal laws relating to the distribution of dangerous drugs and dangerous devices? ☐Yes ☐No

State and Federal laws relating to the distribution of controlled substances? ☐Yes ☐No

The United States Pharmacopoeia standards relating to the safe storage and handling of drugs? ☐Yes ☐No

The safe storage and handling of home medical devices? ☐Yes ☐No

Prescription terminology, abbreviations, and format? ☐Yes ☐No

For all of the above questions answered <u>yes</u>, you must submit appropriate proof to verify qualifications with your application and fee.

5. Certification of Exemptee - Please read carefully and sign below

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the license. I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in this application, including all supplementary statements. I also certify that I personally completed this application and have read and understand the instructions attached to this application.

Applicant Exemptee signature: (in full, no initials)	Date:

HOME MEDICAL DEVICE RETAIL EXEMPTEE LICENSE FEE
00000004040000000G1257004984149A3018

THIS AREA IS TO BE COMPLETED BY THE EMPLOYER

6. Legal Name of Home Medical Device Retailer:	HMDR license number:
Business name: (if different)	
Address of Home Medical Device Retailer:	

7. What type(s) of products are handled at these premises:

- ☐ Legend(prescription) devices
- ☐ Respiratory equipment
- ☐ Parenteral/enteral supplies
- ☐ Rental Beds & equipment
- ☐ Non legend(prescription) devices
- ☐ Other: Please explain below

_____

8. Does this Home Medical Device Retailer currently employ the person whose name appears on this application? ☐Yes ☐No

9. Will this person replace an Exemptee approved by the Department of Health Services? ☐Yes ☐No

Name of Exemptee being replaced _____

Exemptee Certificate Number _____

10. Certification of Employer – Read carefully and sign below

I hereby certify that the application completed on this form is being presented to the Food and Drug Branch with my knowledge and approval. Also, it is my understanding that a person certified by the Food and Drug Branch must be on the premises and actively supervising operations at all times when prescription devices are being dispensed. I certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers, and representations made in the foregoing application, including all supplementary statements.

Employer's signature	Title:	Date

Home Medical Device Exemptee License Application Instructions

Please complete and/or amend this application as is most appropriate to your facility. Include the appropriate fee for each application as indicated in the fee schedule and make check payable to: CALIFORNIA DEPARTMENT OF HEALTH SERVICES. The application cannot be processed without the appropriate fees, complete documentation and appropriate signatures. Unsigned or incomplete applications cannot be processed and will be returned. Penalty for failure to renew the license within 30 days after expiration is an additional $10.00 that must be added to the renewal fee before the license is issued. The following are further instructions on how to complete this application:

1. ***Your Information*:** Your name as it is to appear on the license issued by the Department of Health Services. *Residence address*: is the street address of where you actually live. *City:* is the municipality where the address is located. *State:* is normally California but change to another state if you are located outside the California border. *Zip:* is the five-digit zip.
2. ***Previous Exemptee license number:*** If applicable enter in your current or previously held Exemptee license number.
3. ***Employer Information**:* The legal name of the Home Medical Device retailer to appear on the license issued by the Department of Health Services. *Address:* is the street address of the firm where business will take place. *City:* is the municipality where the address is located. *State*: is normally California but change to another state if the firm is located outside the California border. *Zip:* is the five-digit zip code with 4-digit zip-plus for the location to be licensed.
4. ***Minimum qualifications**: Education:* High school diploma GED or equivalent. Attach copies of any applicable certifications or licenses that you may hold. *Work Experience*: One or more years paid experience, attach dates name(s) of employer(s) and addresses. *Training Programs:* Indicate by yes or no the training you have completed specific to the five topics listed. Attach copies of certificates or transcripts.
5. ***Certification of Applicant:*** After reading the instruction paragraph your signature is needed, please sign in full (no initials) and date.

Numbers 6 through 11 are to be completed by the employer not by the exemptee applicant.

6. ***Firm Information*:** The name of the Home Medical Device Retailer to appear on the license issued by the Department of Health Services. *HMDR license*: state current HMDR license number. *Corporate name:* Name of corporation if different from HMDR name. *Address*: is the street address of the firm where business will take place. *City:* is the municipality where the address is located. *State:* is normally California but change to another state if your firm is located outside the California border. *Zip:* is the five-digit zip code with 4-digit zip-plus for the location to be licensed.
7. ***Type of products to be sold at this firm:*** Check all appropriate boxes indicating types of products sold by this firm.
8. ***Current Employment:*** Check the appropriate box to verify employment.
9. ***Replacement of approved Exemptee:*** *Check box:* if applicant is replacing an approved Exemptee. *Name:* Exemptee being replaced. *Certificate number:* Exemptee being replaced certificate number.
10. ***Certification of Employer:*** After reading the instruction paragraph the employer's signature is needed, please sign, state title of signatory and date the signature. Mail the completed and signed application with the licensing fee(see table below) to:

Department of Health Services
Food and Drug Branch
601 North 7th Street, MS 357
P.O. Box 942732
Sacramento, CA 94234-7320
Attn: Home Medical Device Retail Desk

License Category	*Fee*	*Interval*	*New Application*
Instate retail firm	$850.00	Annually on renewal	On application
Out of State retail firm	$150.00	Annually on renewal	On application
Warehouse only	$425.00	Annually on renewal	On application
Exemptee Application Fee	$100.00	Once on application only	On application
Exemptee License Fee	$150.00	Annually on renewal	On application
Government agency	$0.00	Annual renewal required no fee due	No fee required with application
Non-Profit agency	$0.00	Annual renewal required no fee due	No fee required with application

If you have any questions, please contact the Home Medical Device License Voice Mailbox at (916) 445-5224 and leave a message with your firm name, your name and your phone number and a staff member will return your call. You may also visit our internet web site at: http://www.dhs.ca.gov/fdb/ for timely program news and a blank copy of this application form.